



North Carolina Department of Health and Human Services
Division of Aging and Adult Services

2101 Mail Service Center • Raleigh, North Carolina 27699-2101

Phone 919-733-3818 Fax 919-715-0023

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Dennis W. Streets, Director
919-733-3983

August 3, 2006

DEAR COUNTY DIRECTOR OF SOCIAL SERVICES:

ATTENTION: Adult Protective Services Supervisors

SUBJECT: ASSESSING AN ADULT'S CAPACITY TO CONSENT

The Division of Aging and Adult Services is pleased to announce the availability of a one-day workshop entitled, *Assessing An Adult's Capacity To Consent*. It will be offered in two locations across the state this year.

The workshop will provide participants an excellent opportunity to learn about and discuss mental capacity as it relates to Adult Protective Services (APS). Mental capacity will be defined and the differences and similarities between mental capacity and mental competence will be discussed. Lecture and small group discussion will be used to examine the degrees and components of mental capacity. Principles for determining whether an adult has or lacks capacity to consent to protective services will be explored, including using APS evaluation data to assist with making a decision about capacity to consent. Participants will learn the importance of obtaining help, when necessary, in making a capacity decision, and the importance of accurately and thoroughly documenting how the decision was reached.

Social workers and supervisors with responsibility for evaluating and planning service interventions in APS cases will benefit from attending this workshop. The workshop is being offered as an advanced level training (beyond the APS Basic Skills Training) for APS staff. **All participants should have completed both Modules I and II of the *Adult Protective Services Basic Skills Training* before attending this workshop.** A maximum of thirty participants will be accepted at each of the training sites and registration will be accepted on a first come, first served basis.

Dear County Director
Re: Assessing an Adult's Capacity to Consent
August 3, 2006
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Training Dates

Location

December 14, 2006

Wilson County DSS
100 N.E. Gold Street
Wilson, NC

April 5, 2007

Gaston County DSS
330 N. Marietta Street
Gastonia, North Carolina

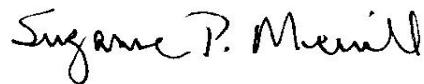
There is no cost for this training, however, **you must pre-register**. A registration form is attached. Please duplicate as needed. Participants can expect to receive a confirmation letter and specific information about the training site after registering. Each workshop **starts promptly at 9:00 a.m.** and will **end by 4:00 p.m.** There will be no on-site registration.

Please choose one of the workshops listed above and complete the attached registration form. If the site you request is full, you will be notified and offered another site, if available. Refreshments will not be provided, however, participants are welcome to bring their own drinks and snacks.

If you need additional information or have questions regarding the content of the workshops, please contact Rosalyn Pettyford at (919) 733-3818, or your Adult Programs Representative. For all questions regarding registration, please contact Monica Nealous, Program Assistant, at the number referenced above.

To **assure registration** at the selected location, send your registration as soon as possible. A completed registration form may be **mailed or faxed** to Ms. Nealous at NC Division of Aging and Adult Services, 693 Palmer Drive, 2101 MSC, Raleigh, North Carolina 27699-2101. FAX: (919) 715-0023. **On-line registration** is also available at ncswLearn.org. The 2006-2007 DAAS Adult Services Training Calendar can be accessed at <http://www.dhhs.state.nc.us/aging/trngcal.htm>

Sincerely,



Suzanne P. Merrill, Chief
Adult Services Section

SPM/

AFS 13-2006

Attachment

Adult Services, NC Division of Aging and Adult Services Registration Form

Have you attended the prerequisites for this training event?

(For prerequisite information please refer to the training description)

☐ Yes ☐ No

☐ Not Applicable for this Training

First Name: _____

MI: _____

Last Name: _____

If you have ever registered for a training under a different name, what is that name? _____

"Goes By" Name: _____

Gender: ☐ Female ☐ Male

Race/Ethnicity (Optional):

☐ Caucasian ☐ African American

☐ Latino/Hispanic

☐ Asian/Pacific Islander

☐ Native American/Eskimo

☐ Mixed Race

Home Phone (please include area code):

() _____

Work Phone & Extension (please include area code):

() _____

Home phone requested in event of last minute postponement due to severe weather.

Your Work E-mail Address: _____

Fax #: () _____

Agency Name: _____

Mailing Address (PO Box, Drawer #, or Street Name and Suite #): _____

City: _____

State: _____

Zip Code: _____

State Courier #: _____

County: _____

Supervisor's Full Name: _____

Supervisor's Phone (please include area code): () _____

Employment Type:

- ☐ Not applicable
- ☐ County DSS - Permanent
- ☐ County DSS - Temporary
- ☐ County Non-DSS
- ☐ Federal Agencies
- ☐ State Agency/Public University
- ☐ Private University/College
- ☐ Private Agency/Business

Work Type:

- ☐ Direct Client Service
- ☐ Line Supervisor
- ☐ Trainer/Staff Development
- ☐ Program Manager
- ☐ Program/Admin. Support
- ☐ Director
- ☐ Other
- ☐ Not Applicable

Program Responsibilities:

If you are **NOT** a county DSS worker, please skip to the next box (Check all that apply)

- ☐ Adult Care Home CMS
- ☐ Adult Day Care
- ☐ Adult Home Specialist
- ☐ Adult Protective Services
- ☐ Adult Services Intake
- ☐ At-Risk Case Management
- ☐ Attorney
- ☐ Guardianship
- ☐ In-Home Aide Services
- ☐ Special Assistance
- ☐ Trainer
- ☐ Other

Other Roles:

Complete this box if you are **NOT** a county DSS worker

- ☐ Aging Services
- ☐ Attorney/Judicial
- ☐ Developmental Disabilities
- ☐ Health/Medical
- ☐ Law Enforcement
- ☐ Long Term Care
- ☐ Mental Health
- ☐ Student/Student Intern
- ☐ Substance Abuse
- ☐ Vocational Rehabilitation
- ☐ Other

Highest Degree

- ☐ HS
- ☐ Associate
- ☐ Bachelor
- ☐ Masters
- ☐ Doctorate

Highest Social Work Degree

- ☐ BSW/BSSW
- ☐ MSW/MSSW
- ☐ PhD/DSW

Training Event

To ensure this registration form is faxed/mailed to the appropriate person please refer to the Dear Director letter to which this was attached

Training Event you are registering for: _____

Date(s) of Training Event: _____

Location of Training Event: _____

If you are replacing a registered co-worker, what is his/her name: _____

If you are making up a missed training day, which day are you making up? _____